AMENDATORY SECTION (Amending WSR 01-18-041, filed 8/29/01, effective 10/1/01)

WAC 296-20-01002 Definitions. Acceptance, accepted condition: Determination by a qualified representative of the department or self-insurer that reimbursement for the diagnosis and curative or rehabilitative treatment of a claimant's medical condition is the responsibility of the department or self-insurer. The condition being accepted must be specified by one or more diagnosis codes from the current edition of the International Classification of Diseases, Clinically Modified (ICD-CM).

Attendant care: Those proper and necessary personal care services provided to maintain the worker in his or her residence. Refer to WAC 296-20-303 for more information.

Attending doctor report: This type of report may also be referred to as a "60 day" or "special" report. The following information must be included in this type of report. Also, additional information may be requested by the department as needed.

(1) The condition(s) diagnosed including ICD-9-CM codes and the objective and subjective findings.

(2) Their relationship, if any, to the industrial injury or exposure.

(3) Outline of proposed treatment program, its length, components, and expected prognosis including an estimate of when treatment should be concluded and condition(s) stable. An estimated return to work date should be included. The probability, if any, of permanent partial disability resulting from industrial conditions should be noted.

(4) If the worker has not returned to work, the attending doctor should indicate whether a vocational assessment will be necessary to evaluate the worker's ability to return to work and why.

(5) If the worker has not returned to work, a doctor's estimate of physical capacities should be included with the report. If further information regarding physical capacities is needed or required, a performance-based physical capacities evaluation can be requested. Performance-based physical capacities evaluations should be conducted by a licensed occupational therapist or a licensed physical therapist. Performance-based physical capacities evaluations may also be conducted by other qualified professionals who provided performance-based physical capacities evaluations to the department prior to May 20, 1987, and who have received written approval to continue supplying this service based on formal department review of their qualifications.

Authorization: Notification by a qualified representative of the department or self-insurer that specific proper and necessary treatment, services, or equipment provided for the diagnosis and curative or rehabilitative treatment of an accepted condition will be reimbursed by the department or self-insurer.

Average wholesale price (AWP): A pharmacy reimbursement formula by which the pharmacist is reimbursed for the cost of the product plus a mark-up. The AWP is an industry benchmark which is developed independently by companies that specifically monitor drug pricing.

Baseline price (BLP): Is derived by calculating the mean average for all NDC's (National Drug Code) in a specific product group, determining the standard deviation, and calculating a new mean average using all prices within one standard deviation of the original mean average. "Baseline price" is a drug pricing mechanism developed and updated by First Data Bank.

Bundled codes: When a bundled code is covered, payment for them is

subsumed by the payment for the codes or services to which they are incident. (An example is a telephone call from a hospital nurse regarding care of a patient. This service is not separately payable because it is included in the payment for other services such as hospital visits.) Bundled codes and services are identified in the fee schedules.

By report: BR (by report) in the value column of the fee schedules indicates that the value of this service is to be determined by report (BR) because the service is too unusual, variable or new to be assigned a unit value. The report shall provide an adequate definition or description of the services or procedures that explain why the services or procedures (e.g., operative, medical, radiological, laboratory, pathology, or other similar service report) are too unusual, variable, or complex to be assigned a relative value unit, using any of the following as indicated:

(1) Diagnosis;

(2) Size, location and number of lesion(s) or procedure(s) where appropriate;

(3) Surgical procedure(s) and supplementary procedure(s);

(4) Whenever possible, list the nearest similar procedure by number according to the fee schedules;

(5) Estimated follow-up;

(6) Operative time;

(7) Describe in detail any service rendered and billed using an "unlisted" procedure code.

The department or self-insurer may adjust BR procedures when such action is indicated.

Chart notes: This type of documentation may also be referred to as "office" or "progress" notes. Providers must maintain charts and records in order to support and justify the services provided. "Chart" means a compendium of medical records on an individual patient. "Record" means dated reports supporting bills submitted to the department or self-insurer for medical services provided in an office, nursing facility, hospital, outpatient, emergency room, or other place of service. Records of service shall be entered in a chronological order by the practitioner who rendered the service. For reimbursement purposes, such records shall be legible, and shall include, but are not limited to:

(1) Date(s) of service;

(2) Patient's name and date of birth;

(3) Claim number;

(4) Name and title of the person performing the service;

(5) Chief complaint or reason for each visit;

(6) Pertinent medical history;

(7) Pertinent findings on examination;

(8) Medications and/or equipment/supplies prescribed or provided;

(9) Description of treatment (when applicable);

(10) Recommendations for additional treatments, procedures, or consultations;

(11) X-rays, tests, and results; and

(12) Plan of treatment/care/outcome.

Consultation examination report: The following information must be included in this type of report. Additional information may be requested by the department as needed.

(1) A detailed history to establish:

(a) The type and severity of the industrial injury or occupational disease.

(b) The patient's previous physical and mental health.

(c) Any social and emotional factors which may effect recovery.

(2) A comparison history between history provided by attending doctor and injured worker, must be provided with exam.

(3) A detailed physical examination concerning all systems affected by

the industrial accident.

(4) A general physical examination sufficient to demonstrate any preexisting impairments of function or concurrent condition.

(5) A complete diagnosis of all pathological conditions including ICD-9-CM codes found to be listed:

(a) Due solely to injury.

(b) Preexisting condition aggravated by the injury and the extent of aggravation.

(c) Other medical conditions neither related to nor aggravated by the injury but which may retard recovery.

(d) Coexisting disease (arthritis, congenital deformities, heart disease, etc.).

(6) Conclusions must include:

(a) Type of treatment recommended for each pathological condition and the probable duration of treatment.

(b) Expected degree of recovery from the industrial condition.

(c) Probability, if any, of permanent disability resulting from the industrial condition.

(d) Probability of returning to work.

(7) Reports of necessary, reasonable X-ray and laboratory studies to establish or confirm the diagnosis when indicated.

Doctor: For these rules, means a person licensed to practice one or more of the following professions: Medicine and surgery; osteopathic medicine and surgery; chiropractic; naturopathic physician; podiatry; dentistry; optometry.

Only those persons so licensed may sign report of accident forms and time loss cards except as provided in chapter 296-20 WAC.

Emergent hospital admission: Placement of the worker in an acute care hospital for treatment of a work related medical condition of an unforeseen or rapidly progressing nature which if not treated in an inpatient setting, is likely to jeopardize the worker's health or treatment outcome.

Fatal: When the attending doctor has reason to believe a worker has died as a result of an industrial injury or exposure, the doctor should notify the nearest department service location or the self-insurer immediately. Often an autopsy is required by the department or self-insurer. If so, it will be authorized by the service location manager or the self-insurer. Benefits payable include burial stipend and monthly payments to the surviving spouse and/or dependents.

Fee schedules or maximum fee schedule(s): The fee schedules consist of, but are not limited to, the following:

(a) Health Care Financing Administration's Common Procedure Coding System Level I and II Codes, descriptions and modifiers that describe medical and other services, supplies and materials.

(b) Codes, descriptions and modifiers developed by the department.

(c) Relative value units (RVUs), calculated or assigned dollar values, percent-of-allowed-charges (POAC), or diagnostic related groups (DRGs), that set the maximum allowable fee for services rendered.

(d) Billing instructions or policies relating to the submission of bills by providers and the payment of bills by the department or self-insurer.

(e) Average wholesale price (AWP), baseline price (BLP), and policies related to the purchase of medications.

Health services provider or provider: For these rules means any person, firm, corporation, partnership, association, agency, institution, or other legal entity providing any kind of services related to the treatment of an industrially injured worker. It includes, but is not limited to, hospitals, medical doctors, dentists, chiropractors, vocational rehabilitation counselors, osteopathic physicians, pharmacists, podiatrists, physical therapists, occupational therapists, massage therapists,

psychologists, naturopathic physicians, and durable medical equipment dealers.

Home nursing: Those nursing services that are proper and necessary to maintain the worker in his or her residence. These services must be provided through an agency licensed, certified or registered to provide home care, home health or hospice services. Refer to WAC 296-20-091 for more information.

Independent or separate procedure: Certain of the fee schedule's listed procedures are commonly carried out as an integral part of a total service, and as such do not warrant a separate charge. When such a procedure is carried out as a separate entity, not immediately related to other services, the indicated value for "independent procedure" is applicable.

Medical aid rules: The Washington Administrative Codes (WACs) that contain the administrative rules for medical and other services rendered to workers.

Modified work status: The worker is not able to return to their previous work, but is physically capable of carrying out work of a lighter nature. Workers should be urged to return to modified work as soon as reasonable as such work is frequently beneficial for body conditioning and regaining self confidence.

Under RCW 51.32.090, when the employer has modified work available for the worker, the employer must furnish the doctor and the worker with a statement describing the available work in terms that will enable the doctor to relate the physical activities of the job to the worker's physical limitations and capabilities. The doctor shall then determine whether the worker is physically able to perform the work described. The employer may not increase the physical requirements of the job without requesting the opinion of the doctor as to the worker's ability to perform such additional work. If after a trial period of reemployment the worker is unable to continue with such work, the worker's time loss compensation will be resumed upon certification by the attending doctor.

If the employer has no modified work available, the department should be notified immediately, so vocational assessment can be conducted to determine whether the worker will require assistance in returning to work.

Nonemergent (elective) hospital admission: Placement of the worker in an acute care hospital for medical treatment of an accepted condition which may be safely scheduled in advance without jeopardizing the worker's health or treatment outcome.

((~~**Permanent partial disability:** Any anatomic or functional abnormality or loss after maximum rehabilitation has been achieved, which is determined to be stable or nonprogressive at the time the evaluation is made. When the attending doctor has reason to believe a permanent impairment exists, the department or self-insurer should be notified. Specified disabilities (amputation or loss of function of extremities, loss of hearing or vision) are to be rated utilizing a nationally recognized impairment rating guide. Unspecified disabilities (internal injuries, spinal injuries, mental health, etc.) are to be rated utilizing the category system detailed under WAC 296-20-200 et al. for injuries occurring on or after October 1, 1974. **Under Washington law disability awards are based solely on physical or mental impairment due to the accepted injury or conditions without consideration of economic factors.**~~))

Physician: For these rules, means any person licensed to perform one or more of the following professions: Medicine and surgery; or osteopathic medicine and surgery.

Practitioner: For these rules, means any person defined as a "doctor" under these rules, or licensed to practice one or more of the following professions: Audiology; physical therapy; occupational therapy; pharmacy; prosthetics; orthotics; psychology; nursing; physician or osteopathic assistant; and massage therapy.

Proper and necessary:

(1) The department or self-insurer pays for proper and necessary health care services that are related to the diagnosis and treatment of an accepted condition.

(2) Under the Industrial Insurance Act, "proper and necessary" refers to those health care services which are:

(a) Reflective of accepted standards of good practice, within the scope of practice of the provider's license or certification;

(b) Curative or rehabilitative. Care must be of a type to cure the effects of a work-related injury or illness, or it must be rehabilitative. Curative treatment produces permanent changes, which eliminate or lessen the clinical effects of an accepted condition. Rehabilitative treatment allows an injured or ill worker to regain functional activity in the presence of an interfering accepted condition. Curative and rehabilitative care produce long-term changes;

(c) Not delivered primarily for the convenience of the claimant, the claimant's attending doctor, or any other provider; and

(d) Provided at the least cost and in the least intensive setting of care consistent with the other provisions of this definition.

(3) The department or self-insurer stops payment for health care services once a worker reaches a state of maximum medical improvement. Maximum medical improvement occurs when no fundamental or marked change in an accepted condition can be expected, with or without treatment. Maximum medical improvement may be present though there may be fluctuations in levels of pain and function. A worker's condition may have reached maximum medical improvement though it might be expected to improve or deteriorate with the passage of time. Once a worker’s condition has reached maximum medical improvement, treatment that results only in temporary or transient changes is not proper and necessary. "Maximum medical improvement" is equivalent to "fixed and stable."

(4) In no case shall services which are inappropriate to the accepted condition or which present hazards in excess of the expected medical benefits be considered proper and necessary. Services that are controversial, obsolete, investigational or experimental are presumed not to be proper and necessary, and shall be authorized only as provided in WAC 296-20-03002(6) and 296-20-02850.

Regular work status: The injured worker is physically capable of returning to his/her regular work. It is the duty of the attending doctor to notify the worker and the department or self-insurer, as the case may be, of the specific date of release to return to regular work. Compensation will be terminated on the release date. Further treatment can be allowed as requested by the attending doctor if the condition is not stationary and such treatment is needed and otherwise in order.

Temporary partial disability: Partial time loss compensation may be paid when the worker can return to work on a limited basis or return to a lesser paying job is necessitated by the accepted injury or condition. The worker must have a reduction in wages of more than five percent before consideration of partial time loss can be made. No partial time loss compensation can be paid after the worker's condition is stationary. **All time loss compensation must be certified by the attending doctor based on objective findings**.

Termination of treatment: When treatment is no longer required and/or the industrial condition is stabilized, a report indicating the date of stabilization should be submitted to the department or self-insurer. This is necessary to initiate closure of the industrial claim. The patient may require continued treatment for conditions not related to the industrial condition; however, financial responsibility for such care must be the patient's.

Total permanent disability: Loss of both legs or arms, or one leg and

one arm, total loss of eyesight, paralysis or other condition permanently incapacitating the worker from performing any work at any gainful employment. When the attending doctor feels a worker may be totally and permanently disabled, the attending doctor should communicate this information immediately to the department or self-insurer. A vocational evaluation and an independent rating of disability may be arranged by the department prior to a determination as to total permanent disability. Coverage for treatment does not usually continue after the date an injured worker is placed on pension.

Total temporary disability: Full-time loss compensation will be paid when the worker is unable to return to any type of reasonably continuous gainful employment as a direct result of an accepted industrial injury or exposure.

Unusual or unlisted procedure: Value of unlisted services or procedures should be substantiated "by report" (BR).

Utilization review: The assessment of a claimant's medical care to assure that it is proper and necessary and of good quality. This assessment typically considers the appropriateness of the place of care, level of care, and the duration, frequency or quantity of services provided in relation to the accepted condition being treated.

NEW SECTION

WAC 296-20-19000 What is a permanent partial disability award? Permanent partial disability is any anatomic or functional abnormality or loss after maximum medical improvement (MMI) has been achieved. At MMI, the worker's condition is determined to be stable or nonprogressive at the time the evaluation is made. A permanent partial disability award is a monetary award designed to compensate the worker for the amputation or loss of function of a body part or organ system. Impairment is evaluated without reference to the nature of the injury or the treatment given. To ensure uniformity, consistency and fairness in rating permanent partial disability, it is essential that injured workers with comparable anatomic abnormalities and functional loss receive comparable disability awards. As such, the amount of the permanent partial disability award is not dependent upon or influenced by the economic impact of the occupational injury or disease on an individual worker. Rather, Washington's Industrial Insurance Act requires that permanent partial disability be established primarily by objective physical or clinical findings establishing a loss of function. Mental health impairments are evaluated under WAC 296-20-330 and 296-20-340.

NEW SECTION

WAC 296-20-19010 Are there different types of permanent partial disabilities? Under Title 51 RCW, there are two types of permanent partial disabilities.

(1) Specified disabilities are listed in RCW 51.32.080 (1)(a). They are limited to amputation or loss of function of extremities, loss of hearing or loss of vision.

(2) Unspecified disabilities include, but are not limited to, internal

injuries, back injuries, mental health conditions, respiratory disorders, and other disorders affecting the internal organs.

NEW SECTION

WAC 296-20-19020 How is it determined which impairment rating system is to be used to rate specified and unspecified disabilities? (1) Specified disabilities are rated in one of two ways:

(a) Impairment due to amputation, total loss of hearing, and total loss of vision are rated according to RCW 51.32.080;

(b) Impairment for the loss of function of extremities, as well as partial loss of hearing or vision, is rated using a nationally recognized impairment rating guide unless otherwise precluded by department rule.

(2) Unspecified disabilities are rated in accordance with WAC 296-20-200 through 296-20-660.

NEW SECTION

WAC 296-20-19030 To what extent is pain considered in an award for permanent partial disability? The categories used to rate unspecified disabilities incorporate the worker's subjective complaints. Similarly, the organ and body system ratings in the AMA *Guides to the Evaluation of Permanent Impairment* incorporate the worker's subjective complaints. A worker's subjective complaints or symptoms, such as a report of pain, cannot be objectively validated or measured. There is no valid, reliable or consistent means to segregate the worker's subjective complaints of pain from the pain already rated and compensated for in the conventional rating methods. When rating a worker's permanent partial disability, reliance is primarily placed on objective physical or clinical findings that are independent of voluntary action by the worker and can be seen, felt or consistently measured by examiners. No additional permanent partial disability award will be made beyond what is already allowed in the categories and in the organ and body system ratings in the AMA guides.

For example:

! Chapter 18 of the 5th Edition of the AMA *Guides to the Evaluation of Permanent Impairment* attempts to rate impairment caused by a patient's pain complaints. The impairment caused by the worker's pain complaints is already taken into consideration in the categories and in the organ and body system ratings in the AMA guides. There is no reliable means to segregate the pain already rated and compensated from the pain impairment that Chapter 18 purports to rate. Chapter 18 of the 5th Edition of AMA *Guides to the Evaluation of Permanent Impairment* cannot be used to calculate awards for permanent partial disability under Washington's Industrial Insurance Act.